Petition for Workers' Compensation Mediation Conference Please read other side before completing this form	Date Stamp (for office use only)
1. Workers' Name:	Social Security Number: **(Optional)**
Telephone Number:	WC Claim Number:
Date of Accident:	Part of Body Injured:
2. Petitioner's Name: Address: City, State, Zip: Telephone Number:	
3. If you will not be representing yourself in the mediation process, give the following information about your representative: Name: Address: City, State, Zip: Telephone Number:	
4. Respondent's Name: Address: City, State, Zip: Telephone Number:	
5. Respondent's Representative (if any): Address: City, State, Zip: Telephone Number:	
6. What is your dispute with the respondent?	
7. What attempt have you made to resolve your dispute with the respondent?	
8. What was the respondent's reply to your demand?	
Conferences are scheduled by telephone.	
Signature:	Date:

Revised 3/2006

Petition for Workers' Compensation Mediation Conference

Notice: Under Montana law, parties must attempt to resolve their disputes **BEFORE** seeking mediation. Mediation is required in most cases before a petition may be filed in the Workers' Compensation Court. If you have not attempted to resolve your difference with the respondent as required by law, the mediator may be asked to vacate or postpone the conference. To avoid this, make sure you have done the following before filing this petition:

(1) Tell the respondent, in writing, what you want and why you think you are entitled to it.
(2) Give the respondent 15 working days to respond to your request. You may file for mediation sooner if your request is denied before 15 working days have passed.

When mailing the mediation petition to us:

(A) Attach copies of any information you will use during the mediation conference. This information can include medical reports, wage records, statements, etc. If the documents are not available when mailing this petition, you may send them to the mediator and respondent prior to the mediation conference.
(B) If available, attach a copy of the **First Report of Injury** for your claim.

If you have questions about these requirements or about filling out this form, you may call or write us at the telephone number or address listed below.

EMPLOYMENT RELATIONS DIVISION
WORKERS' COMPENSATION MEDIATION
1805 PROSPECT AVE
PO BOX 1728
HELENA MT 59624-1728

Telephone No: (406) 444-6534
FAX No: (406) 444-6854